Pain Management: A Synopsis

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Pain is a SUBJECTIVE experience in which psycho-emotional as well as somatic factors have a direct bearing on perception and outcome.

Always ASK the patient to rate his/her pain on a scale of 0-10, zero being no pain at all and 10 being the worst pain they can imagine. BELIEVE the patient when they give you their pain scale rating. If psycho-emotional factors seem to **"exaggerate"** their perception of pain you should be able to use the "power of Persuasion", as well as medications, to effectively decrease the patient's pain.

The most important aspect of pain management is ESTABLISHING A POSITIVE RELATIONSHIP with the patient. You must CONVINCE them that you know what you're doing and that YOU CAN MAKE THEM BETTER. Once you have their trust and support you're half way there.

Next you must GET THEM TO COOPERATE as a "Pain Team Member". They need to know that successful pain management depends on THEM as well as you. Their job is to let you know how effective your therapy plan is working and to ASK for PRN medication when they need it (if inpatients).

Follow up with them OFTEN (daily until stabilized) to let them know you haven't forgotten them and to "fine tune" their pain management regimen.

Chronic Pain

Most pain management consults are for chronic pain cases (cancer, back/spinal pain, AIDS, etc.). The following guidelines are for the chronic pain patient.

Chronic pain management is like building a house. First you lay the foundation, then you frame the house, then you put on the roof.

The Foundation is ALWAYS a non-narcotic analgesic. Use an NSAID unless contraindicated (Hx. of GI bleed, renal compromise, Hx. of allergy, anti-coag Tx.). My NSAIDS of choice are Naprosyn 500 mg Q8H-Q12H with food or Motrin 800 mg Q8H with food. If the patient cannot take NSAIDS then give Tylenol 975 mg (3 tabs) Q8H (unless pt. has severe hepatic problems). These non-narcotics must be given ROUTINELY, not on a PRN basis.

The frame of the house is a SUSTAINED RELEASE OPIOID, preferably morphine sulfate. Our current formulary item is Oramorph-SR 30 mg. To determine HOW MUCH sustained release narcotic to give them you must add up all the current narcotics they are taking and use a DOSAGE CONVERSION CACULATOR to convert to a single agent. I use the one from Jannsen Pharmaceutica Inc., the makers of Duragesic Patches. You simply add up the EQUIVALENT dosages of all opioids that the patient is taking and convert them to the SINGLE agent of your choice. If someone can take medications orally I recommend using Morphine as a first line agent. If they are allergic to morphine or cannot take meds by mouth then use Duragesic (which is more cumbersome and much more expensive).

Sustained release opioids are ALWAYS taken ROUTINELY, never PRN.

The roof of our pain management house is an immediate release opioid for breakthrough pain. You must ALWAYS give chronic pain patients an agent for breakthrough pain, NO EXCEPTIONS. Try to use the same agent as the sustained release medication. My favorite is Morphine 15 mg sublingual tablets by Lilly. They are very small, rapidly absorbed under the tongue, fast acting and can be given to patients who are basically NPO. The dosage of the immediate release narcotic should be one-third to one-half of the dose of the sustained release narcotic.

For example, if your patient is taking Oramorph-SR 30 mg Q8H, the MSIR dose would be 15 mg SL QI-2H prn. If he/she is taking Oramorph-SR 60 mg Q6H, the MSIR dose would be 15-30 mg QI-2H prn.

Dosage Adjustments: Have the patient note on a calendar the amount and time of day that he/she takes any breakthrough pain meds. This will give you an idea when the pain is worse on a 24 hour cycle. The GOAL is to have a patient take no more than 3 doses of breakthrough narcotic per day. Your job is to add up all the breakthrough doses in 24 hours and "convert" one-third to one-half of this into the sustained release narcotic.

For example: If your patient is taking Oramorph-SR 30 mg Q8H and he/she is taking between 60-90 mg of MSIR per day (4-6 15 mg SL tabs) you would increase his/her Oramorph dose to 60 mg QI2H.

Important notes

• Individualize and adjust the route, dosage, and schedule as needed to obtain a consistent pain scale rating of 2-3.

• Always administer analgesics ROUTINELY for chronic pain patients.

• Give infants and children adequate opioid doses.
Follow patients closely (daily by phone, etc.), particularly when beginning or changing analgesic regimens.

• When changing from one opioid to another, use equi-analgesic doses, then modify the dosage based on the clinical situation and response to the new medication.

• Recognize and treat side effects: NSAIDS: GI bleed, gastritis, platelet inhibition. Opioids: obtundation (rare with chronic narcotic users), mental status changes (more common with Duragesic), itching (all narcs), and constipation (all narcs). For constipation I suggest starting with 6-8 dried prunes a day and titrating up to a bowel movement at least every other day. If prunes are not effective,

don't stop them, just add Lactulose 30 ml BID until the "great movement" occurs, then back off to QD until stools loose, then DIC (but keep taking the prunes).

• Never use mixed agonists-antagonists (Talwin, Stadol, etc.). Never use Demerol in patients with ANY kind of renal compromise. Never use Darvocet **or** Tramadol (Ultram).

• Don't use placebos to assess the nature of pain.

• The worse the pain is, the more difficult to alleviate and the more narcotics you'll have to use initially to alleviate it. Urge patients to take their breakthrough meds at the first signs of "discomfort" (above the 2-3 pain scale) and not to wait until they can't stand the pain.

• Watch for the development of tolerance and treat appropriately.

• Be aware of the development of physical dependence and prevent withdrawal by assuring the patient has an adequate supply of narcotics. When you wean them, do it slowly; keeping the pain scale rating at 2-3 throughout the process.

• Do not label a patient "addicted" (psychologically dependent) if you merely mean physically dependent on, or tolerant to, narcotics. "Drug Seeking Behavior" is VERY different from physical dependence.

• If signs and symptoms of DEPRESSION persist after adequate pain management is obtained then treat with SSRI's or other appropriate agents.

Commonly Prescribed Adult Doses of Oral Analgesics

General Philosophy

Whenever possible in cases of acute pain, and always in cases of chronic pain, use non-narcotic analgesics as a base. Use routinely when appropriate.

Non-Narcotic Analgesics (mild to moderate pain).

NSAIDS (the best due to anti-inflammatory effects). Always given with food.

Ibuprofen (Motrin, Advil):
400-800 mg q6h prn. Use routinely for first 24-48 hours in acute pain cases, then PRN. Use routinely in chronic pain patients unless contraindicated.

Naproxen (Naprosyn, Alleve):
500 mg BID. Personally I like 500-750 mg BID but this exceeds "traditional" dosing. Use routinely in chronic pain patients unless contraindicated.

Acetaminophen (Tylenol, APAP):
Often included in narcotic analgesics for synergistic effects. Not as effective as the NSAIDS, but fewer serious side effects like GI bleeding. Remember: maximum daily dose is 4 gms in adults.

Narcotic Analgesics (moderate to severe pain).

Many physicians underprescribe narcotics due to fear of addiction (which is extremely rare) and lack of pain management understanding.

Remember: Pain is a very subjective and variable phenomenon, you have to believe and accept your patients' assessment of their pain; and treat accordingly

Remember: The most difficult situation in pain management is to have to play "pain catch up", that is, to initially underprescribe analgesics, then try to alleviate the pain you could have dealt with more appropriately from the beginning.

Darvocet N-100 (propoxyphene/APAP) Ineffective. Do not recommend.

Tylenol w/Codeine (APAP 325 mg w/Codeine, TC#2 = 15 mg, TC#3 = 30 mg, TC#4 = 60 mg). (TC#3 is most common) 1-2 tabs Q4-6H pm pain. An effective analgesic for moderate pain. Limited in use by codeine side effects of nausea/vomiting, and mentation changes.

Vicodin (APAP/Hydrocodone) 1-2 tabs Q4-GH prn pain. More powerful than Tylenol w/Codeine. Has the advantage of not requiring a C-II duplicate Rx.

Percocet (APAP/Oxycodone) Moderate:1 tab Q3-4H prn pain. Severe:1-2 tabs 04h prn pain. The gold standard of narcotic analgesics for more severe pain. Excellent pain relief with few side effects. Percocet's disadvantage is that it requires a C-II duplicate Rx. Do not hesitate to use in cases of moderate to severe pain.

Morphine (immediate release) 15 & 30 mg tabs. 15-30mg SL Q3-4H prn pain. Very useful in cases of severe pain that does not respond to Percocet. Advantage is that Lilly makes a sublingual tablet that can be given to patients with nausea/vomiting or restricted PO intake. May use in very high doses for patients with significant narcotic tolerance.

Sustained release Morphine. Only used in chronic pain mgmt. Usually dosed Q8H routinely. Recommend MS Contin, which comes in 15, 30, 60, 100 and 200 mg strengths (each color coded to minimize dosing errors) or Oramorph-SR. No maximum dose.

Duragesic Patch (Fentanyl). Only used in chronic pain mgmt. Usually dosed Q72H. Comes in 25, 50, 75 and 100 mcg/hr patches. Max. dose approx. 400 mcg/hr.

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Pain Glossary

Narcotic
"Narcotic" is a legal, not a scientific term which denotes some of the drugs that are controlled under the Single Convention on Narcotic Drugs, 1961, and the U.S. Controlled Substances Act (CSA). Under the Single Convention and CSA, substances such as the opioids are classified as narcotics. Marijuana and cocaine are also legally classified as "narcotics." When discussing pain relief, we avoid use of "narcotic", preferring "opiate" or "opioid".

Opiate
"Opiate" refers to drugs whose origin is the opium poppy, including codeine and morphine.

Opioid
"Opioid" is a scientific term denoting both natural (codeine, morphine) and synthetic (methadone, fentanyl) drugs, and whose pharmacological effects are mediated by specific receptors in the nervous system. "Opioid" also applies to agonists and antagonists with morphine - like activity.

Tolerance
"Tolerance" refers to the physical adaptation of the body to an opioid resulting in the need to increase the dose to achieve the same effect, as in "analgesic tolerance", or as in the reduction in a response (such as sedation) with repeated administration of drug.

Physical dependence
"Physical dependence" also describes the physical adaptation of the body to the presence of an opioid; it is characterized by signs of withdrawal when use of an opioid is stopped abruptly, or when an opioid antagonist is administered to an individual who has been on chronic opioid therapy.

Psychological dependence
"Psychological dependence" is a behavioral pattern characterized by a compulsion to obtain a drug for mood altering effects.

Addiction
"Addiction" is a sociologic term which refers to compulsive drug use, psychological dependence, and continuing use despite harm. Neither physical dependence nor tolerance are sufficient to define "addiction." In the past as well as in present day language "addiction" is frequently and incorrectly equated with physical dependence and withdrawal. "Addiction" and related terms such as "addict" are used in narcotic control laws and are sometimes inappropriately defined to include physical dependence, thereby confusing pain patients with addicts.

Cancer Pain Relief, Second Edition, With a guide to opioid availability, World Health Organization, 1996.

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Remember: Whenever you are using a sustained release narcotic analgesic you must write additional orders for immediate acting narcotics for breakthrough pain.

Equivalencies:

Narcotic	Equi-analgesic Dose (Only oral potencies listed)	
Codeine	60 mg	
Morphine	15 mg	all values approximate
Hydrocodone	10 mg	
Oxycodone	7.5 mg	

Duragesic 25 mcg = 30-60 mg oral morphine

Editor's Note

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